Medical reports on persons claiming compensation for personal injury

P Cornes PhD **R C B Aitken** MD *Disability Management Research Group, University of Edinburgh, Canaan Park, Astley Ainslie Hospital, Edinburgh EH9 2HL*

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Summary

An audit of one insurance company's files on all employer's liability and third party motor claims settled over two years for £5000 or more presented an opportunity to review the medical reports on the patients involved. A stratified random sample of files on 203 patients contained 602 reports prepared by 400 consultants. Content analysis was undertaken to evaluate compliance with published guidance on reports prepared for medico-legal purposes and to ascertain how well reports met recipients' requirements. While clinical topics were well covered, generally to a high standard, other functional, psychosocial and occupational topics, reflecting the wider clinical and non-clinical frame of reference within which lawyers and insurers normally seek information and advice, were covered less frequently, extensively and comprehensively - leaving considerable scope to improve these aspects of assessment and reporting. Further review of this aspect of professional practice should include attention to the appropriateness of existing guidance, postgraduate training requirements and the involvement of other agencies or professions in some aspects of assessment for medico-legal purposes.

Introduction

The medical profession receives frequent requests to report on patients seeking compensation for personal injury and related losses, mostly following accidents at work or road accidents. Although professional literature includes occasional guidance on this task[1,2], formal training is seldom provided. Generally, requisite knowledge and skill are acquired informally, through experience gained in responding to requests for reports and advice from experienced colleagues. Not surprisingly given the essentially private nature of this professional task, a literature search did not reveal a single example of its evaluation. How well medical reports prepared for medico-legal purposes meet the requirements of those who commission them would appear to be a question that has not been addressed previously.

An audit of one insurance company's files offered a unique opportunity to review medico-legal reporting on the claimants involved. The review had three aims: (1) to analyse compliance with published guidance on preparation of reports for medico-legal purposes; (2) to evaluate the extent to which reports meet the requirements of the lawyers and insurers who request them; (3) to consider if there is scope to improve this aspect of professional practice in order to enhance the value of reports to recipients.

Materials and method

The medical reports reviewed were located in the files on all employer's liability (n=209) and third party motor claims by persons of working age (n=773) that had been settled for £5000 or more (range £5000-£305 000; mean £16,298; median £10 000) over a period of two years by one British insurance company. The lower limit marked approximately the boundary between claims involving absence from work of 6 months or longer and those with less serious consequences.

The 982 accident victims were predominantly young and male (Table 1). Abbreviated Injury Scale[3] gradings of main injury were 'minor' for 10%, 'moderate' for 31%, 'severe' for 39%, 'serious' or 'critical' for 6% and 'fatal' for 14%. For 855 survivors, location of main injury was in the pelvic/lower limb region in 42% of cases, followed by injuries to head or face (21%), shoulder/upper limb (16%), neck or spine (15%) and chest/internal organs (5%). Fractures (54%), closed

Table 1. Age and sex of accident victims

	Male		*Female*		*Total*	
Age	n	%	n	%	n	%
20 years or less	160	22	51	21	211	22
21-30	170	24	49	20	219	23
31-40	136	19	51	21	187	20
41-50	111	16	37	15	148	15
51 years or more	136	19	54	22	190	20
Total	713	100	242	99	955*	100

*No age data for 22 male and 5 female patients

Table 2. Representativeness of the sample

	Employer's liability claimants			*Third party motor claimants*		
Variable	χ^2	*d.f.*	*P*=	χ^2	*d.f.*	*P*=
Age	1.97	4	0.74	6.77	4	0.15
Sex	1.03	1	0.31	2.27	1	0.13
Occupation	0.81	3	0.85	0.96	4	0.92
Number of injuries	0.22	3	0.97	3.49	3	0.32
Severity of injury	2.06	3	0.56	1.66	4	0.80
Return to work	0.13	1	0.72	0.14	1	0.79
Time to settlement	1.51	2	0.47	2.17	2	0.34
Amount of damages	5.53	3	0.14	3.28	3	0.35

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Table 3. Specialties requested to supply medical reports

Specialty	*Number of consultants*
Orthopaedic surgery	255
Neurology/neurosurgery	42
Ophthalmology/ophthalmic surgery	25
General surgery	17
Plastic surgery	14
General practice	12
General physician	5
Psychiatry	5
Ear, nose and throat surgery	5
Dermatology	4
Urology	4
Oral/maxillo-facial surgery	3
Thoracic surgery	2
Rehabilitation medicine	2
Audiology	1
Gynaecology	1
No information	3
Total	400

head injury (12%) and soft tissue injury, mainly to the cervical/lumbar spine (12%), were the most frequently occurring injuries.

A stratified random sample of insurance files was drawn using sampling ratios of 1 : 2 for employer's liability and 1 : 6 for motor cases. The 102 employer's liability files included three fatal accidents and five other cases for which medical reports were not available, leaving 94 cases for analysis. The 130 motor claims files included 20 fatal accidents and one without medical reports, leaving 109 for analysis. There were no statistically significant differences between selected and unselected cases (Table 2).

The 203 files contained 602 medical reports, ranging from 35 with a single report to one containing 11 reports. These had been prepared by 378 consultants, 10 senior registrars and 12 general practitioners (the 'consultants'). The specialty most frequently requested to provide reports was orthopaedic surgery (64%). Other specialties were much less frequently involved (Table 3). Most consultants (253) supplied a single report. However, 101 prepared two, 37 prepared three and, in nine cases, the same consultant submitted as many as four reports. The number reporting on individual claimants varied from 79 cases involving one consultant to three cases in which six were involved.

The first stage of analysis focused on *each consultant's compliance* with guidance[2] on medico-legal reporting which outlined 28 'essentials' of a medical report. It was held that all needed to be addressed if reports were to provide recipients with a full and detailed account of all medical problems, enabling them to form a well-informed and balanced view and to decide on future action. Compliance was measured by the frequency with which each consultant's report/s on individual claimants covered each 'essential'.

For the second stage of analysis, which examined the extent to which reports met recipients' requirements, the focus shifted to the *content of all medical reports* on each claimant available before claims were settled. Preliminary review with recipients of a series of medical reports highlighted 13 main themes addressed in medical reports and recipients' reasons for seeking such information (Table 4).

Content analysis was undertaken in two ways. First, all passages in the reports addressing each main theme were identified. Proportionate coverage was then calculated by counting the number of words on each theme and expressing it as a percentage of the total for each individual and, averaged out, for the sample as a whole. Having established a quantitative framework, the content of observations was examined. All reporting on each theme was tape recorded, transcribed and subdivided into clusters dealing with common subject matter. This procedure revealed, for the sample as a whole, the nature and scope of information on each theme currently available to recipients of medical reports. Results for four themes - residual disability, occupational information, employment handicap and rehabilitation - are reported.

Results

Compliance with published guidance

Consultants' compliance with the 28 'essentials' of medical reports (Table 5) indicates that a common core of mainly clinical topics (incident and its immediate effects, rate and state of recovery, treatment received between accident and medical examination,

Table 4. Medico-legal reporting themes and recipients' requirements for information and advice

Reporting theme	*Recipients' requirement*
Incident	Contributory liability
Injury and its effects	Full details of injury/impairment; calculation of general damages for pain and suffering
Treatment/response to treatment	Account of medical treatment received; need for further treatment; loss of life expectancy
Complaints	Discrepancy between complaints and findings
Medical examination findings	
Residual disability/prognosis	Severity and permanence of residual disability; likelihood of further recovery/deterioration; possible future complications
Handicap	Future loss of amenity; future loss of earnings; loss of standing in the labour market
Occupation	Employment history; nature of job and/or working conditions; time off work; loss of earnings; potential to return to work in partial/full capacity; special work requirements
Medical history	Other contributory factors or possible causes of injury/impairment
Psychological reaction	Cognitive deficits; behavioural problems; traumatic neurosis; functional overlay
Personal circumstances	Special needs regarding accommodation, mobility, continuing assistance or nursing care
Rehabilitation	Need for referral to other medical, social or vocational rehabilitation services
Miscellaneous	Description of surgical procedures or other investigations that could be undertaken; arrangements for medical examination

Table 5. Consultants' compliance with guidance on medico-legal reporting

Topic to be included in medico-legal report	*Compliance Number*	*Per cent*
Identification		
1 Recipient of report	236	59
2 Patient's name	400	100
3 Patient's address	369	92
4 Patient's age	302	76
5 Patient's occupation	296	74
6 Patient's marital status	149	37
7 Patient's hobbies	103	26
8 Patient's social history	24	6
9 Consultant's name	400	100
10 Consultant's qualifications	350	88
11 Consultant's appointments	339	85
12 Consultant's experience	4	1
Medical examination		
13 Date of examination	384	96
14 Place of examination	346	87
15 Duration of examination	5	1
16 Patient's consent	9	2
Medical history		
17 Patient's medical history	196	49
Incident and treatment		
18 Account of incident	388	97
19 Immediate effects	386	97
20 Rate and state of recovery	389	97
21 Treatment received	384	96
22 Present complaints	385	96
Examination findings		
23 General examination	52	13
24 Special examination	394	99
25 Special investigation	176	44
Opinion		
26 Consistency between incident, complaints and findings	151	38
27 Cause of conditions found	330	83
28 Prognosis	380	95

Base: 378 consultants, 10 senior registrars and 12 general practitioners reporting on 94 employer's liability and 109 third party motor claimants

complaints, examination findings and prognosis) receives almost universal attention. Most exceptions are attributable to general practitioners' briefer reports. More surprising, from a clinical perspective, are lower rates of compliance in reporting that a medical history had been recorded ('nil' or 'none relevant' were accepted as meeting this criterion) or in stating that a general medical examination had been undertaken.

Other topics with lower rates of compliance fall into two categories. First, references to consultants' experience, duration of medical examinations on which reports are based and patients' consent are made in 2% or less of the 400 consultants' reports. The second category concerns patients' socio-demographic details. Apart from names and addresses, omissions of potentially relevant personal, social and occupational information are quite noticeable. For example, one quarter of consultants do not specify patients' ages and occupations (even job titles) and patients' family circumstances or social history are mentioned even less frequently, by one in 20 consultants, mainly neurologists or psychiatrists.

Table 6. Proportions of medical reports devoted to coverage of main reporting themes

Main theme	*Average coverage (%)**	*Number of cases†*
Description of incident	5.3	200
Injury/impairment	6.2	203
Treatment and response	20.6	202
Patient's complaints	11.3	199
Medical examination	23.7	202
Disability/outlook	13.2	199
Handicap	4.1	184
Occupational information	4.6	193
Medical history	2.3	137
Psychological reaction	1.5	88
Personal/social information	0.8	81
Rehabilitation	0.4	24
Miscellaneous observations	6.0	181
Total (%)	100.0	
Base (number of cases)		203

*Average for all 203 claimants
†Actual number of cases in which reporting referred to each theme

Content analysis

The first stage of content analysis calculated the average amount of coverage accorded to each main theme (Table 6). Two-thirds of all reporting is devoted to description of the incident, the resulting injuries and their treatment, patients' complaints and the findings on medical examination. Clinical themes, therefore, also receive the most extensive coverage.

Other aspects of concern to recipients, because they embrace the wider clinical and non-clinical frame of reference for negotiation of personal injury claims, are restricted to the remaining third. Some - including residual disability, occupational information and potential employment handicap - are also addressed in reporting on most cases. Others - including references to rehabilitation - are addressed much less fully or frequently. The second stage of content analysis examined these aspects in more detail.

Residual disability: Commentary on lost or reduced functions, amounting to approximately 70 000 words, was found in reporting on all but four patients. It embraces three broad topics - expected permanence of disability, likelihood of future complications (eg osteoarthritis or epilepsy) and severity of disability. Generally, the first two topics are reported clearly and appropriately, providing recipients with a good picture of what the future is likely to hold in store for each patient. In contrast, in many - if not most - cases, anticipated functional loss is expressed in generalized and imprecise terms. Observations like 'the usual limitations of inversion/eversion of the foot' or 'impaired manual dexterity' are commonplace.

Occupational information: Information about return to work is provided in reporting on 186 patients, leaving 17 for whom no information is provided. Consultants' comments on this subject, amounting to approximately 14 000 words, comprise several constituent clusters. The main cluster, embracing reports that patients have returned to work, accounts for 58% of observations in which this topic is broached. Other references are to those who returned to work

only to be made redundant (6%); who tried to return to work but failed, mainly because they were not yet fully fit (9%); who were fit for work but unemployed (20%); or who were still medically unfit for work (7%), including some who were unlikely to work again. The unemployed category includes some patients who made repeated efforts to find employment but without success, and also the small proportion of patients in whose cases poor motivation, malingering or functional overlay was suspected.

Other occupational topics are covered less frequently and extensively, with approximately 8000 words of commentary on 117 patients. The number of cases with no information of this kind therefore is quite large. Most references are to time off work (104 cases), with information about work record (32 cases) and working conditions (31 cases) only provided for a minority.

Employment handicap: Comments on this aspect of social disadvantage, comprising 13 000 words, are found in reports on 160 patients (with other dimensions of handicap mentioned in another 24 cases). Such observations comprise five main clusters. The largest (47%) concerns instances in which functional limitations are expected to impede work performance. The next largest (25%) is closely related, embracing cases in which consultants are of the opinion that patients should seek lighter work or alternative employment of a wholly or mainly sedentary nature. Two smaller clusters, each accounting for a further 5%, also focus on difficulties patients might encounter on re-entering the labour market. One concerns the possible effects of injury on their standing in the labour market should they be obliged to change employment. The other concerns the small proportion of patients with very severe disabilities who are not expected to return to work for some time, if at all. Some degree of employment handicap is expected for 82% of these patients. The fifth cluster (18%) concerns cases in which no handicap is expected.

Rehabilitation: Examination of medical reports does not suggest that high priority is attached to onward referral of personal injury claimants to occupational therapists or vocational rehabilitation services. Relevant references, totalling less than 2000 words, are found in reports on only 24 patients, with no reference in the remaining 179 cases. Whilst it is unlikely that all patients either need or have potential to benefit from such referral, the low number of cases in which rehabilitation is considered suggests that the option of referral to relevant services is not exercised to its fullest potential. This is reinforced by the fact that 24% of references to rehabilitation only identify need for referral rather than report actual contact with services. Fewer than one in 20 patients had reported contacts with occupational therapy services, industrial therapy units or Employment Department rehabilitation, training and employment services for disabled people.

Discussion

Both lines of analysis suggest a similar conclusion that, while a common core of clinical themes is the most frequently and extensively reported upon, other aspects are dealt with less adequately.

Information on the nature of injuries resulting from accidents, the effects of treatment and any persisting symptoms and physical signs, is generally of a high standard. Recipients therefore appear to be well served with regard to information and advice needed to reach conclusions, for example, about general damages for pain and suffering, future medical or surgical treatments and life expectancy. Also adequate information is usually provided to enable a judgement to be made about the consistency between patients' complaints and medical examination findings. The one clinical theme which is perhaps not always given sufficient attention is the recording and description of previous medical history. Even the absence of a pre-accident medical complaint should be recorded.

In general, less frequent and comprehensive coverage is given to the functional consequences of injury, any resulting social and vocational handicap and any need for rehabilitation services. Yet, even in the case of apparently straightforward orthopaedic problems, such aspects can be of considerable importance to lawyers and insurers determining compensation awards and are included in the limited advice on medical report preparation available in professional literature. It would appear that there is ample scope to improve reporting on these aspects.

For example, reporting on restricted activities may have an unduly prohibitive tone. This could be particularly unhelpful if expression of restrictions in reports is reflected in advice actually given to patients. The standard approach simply lists activities to be avoided. How such advice might be perceived by a patient who is apprehensive about resuming employment is not difficult to imagine. Clearly, patients who are counselled to avoid lifting weights of more than a particular amount or to avoid jobs requiring them to be on their feet for more than a given time will have a wider range of jobs from which to choose than those who are advised to avoid lifting and standing. Opinion based on subjective 'rules of thumb' rather than objective, formal assessments is likely to be of limited helpfulness to recipients of reports, as well as to patients and their employers. Whenever possible, functional limitations should be formally assessed, either in hospital or by referral to other agencies or professions qualified to undertake this task.

It is essential that basic information about occupation is provided in medical reports. Recommendations for lighter and/or sedentary occupations could also be much more specific and job-related. Much current advice appears to disregard the strictures of Hill and Watson-Jones about the non-availability of light work, made as long ago as 1937 in BMA evidence[4] to the Delevigne Committee on the rehabilitation of persons injured by accident[5].

The medical reports studied did not include a single example to suggest that job re-design, adaptation of equipment or premises or provision of special aids to employment had been considered. More frequent consideration of such possibilities should have enabled more patients to return to work or to do so sooner. But these options would require more frequent referral of patients to specialist services for more detailed occupational assessment or advice. It is noteworthy that files on this series of working age patients did not include a single report from an occupational therapist, occupational psychologist, ergonomist or specialist in occupational medicine.

It is arguable that the more neglected aspects of reporting are often the most indispensable if medical

reports are to fulfil all their declared purposes. However essential detailed clinical information is, it is the non-clinical information that helps recipients to locate an injured party as a whole person in a relevant medical, social and economic context and hence to reach fair and valid conclusions about such matters as the reasonableness of complaints, how far the accident was responsible for conditions found on examination and the likely effects of injury on the patient's potential to earn a living and resume pre-accident domestic and leisure pursuits. Future guidance therefore may need to place greater emphasis on achievement of a better balance between clinical and non-clinical aspects of reporting.

The fact that medical reports do not comply with the limited guidelines available to the medical profession would indicate a need to review this aspect of practice. It is necessary to confirm the appropriateness of the guidance available both in terms of doctors' responsibility in supplying the information and recipients' need for it. Improvement of reporting standards, therefore, is not a matter for the medical profession alone. Wider consultation with the lawyers and insurers who commission medical reports would undoubtedly benefit all parties.

Results from this study suggest that consultants may not have the time and/or access to other professional resources to undertake more formal assessments of residual function; that they may not possess the detailed knowledge of jobs, working conditions and operation of the labour market needed to provide adequate occupational assessment and advice; and that only a small minority of patients are referred to the professions or services which specialize in these aspects of assessment. This would indicate that any action taken to enhance the quality and relevance of this hitherto unevaluated professional task should look beyond revision of existing guidance to bring it into line with current reporting procedures and conventions. Other issues that should be addressed in this context include provision of postgraduate training in this aspect of professional practice and the need for follow-up studies to evaluate the reliability and validity of some of the information, assessments or advice currently provided in reports. Opportunity should also be taken to consider whether lawyers' and insurers' requirements would be better met through the more extensive involvement in functional, social and occupational aspects of assessment of other services or professions, acting individually or as members of multiprofessional teams contributing to a single, agreed report.

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